DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/09/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ALZ CARE CENTER	**6428 CRYSTAL DEW DRIVE, LAS VEGAS, NEVADA ,89118**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint State Licensure survey and wellness check initiated at your facility on 04/30/19 and finalized on 05/09/19. This State Licensure survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed to provide care to ten elderly and/or disabled residents with endorsements for Alzheimer's disease and/or chronic illness, Category II beds. The census at the time of the survey was seven. Seven resident files were reviewed and three employee files were reviewed. There was one complaint investigated. Complaint #NV00056887 was substantiated. The allegations a resident fell and broke a hip at the facility, a resident fell out of bed while asleep at night and was left to lie on the floor until the morning, a resident fell out of bed and was not provided assessment or medical care/attention when in pain in a timely manner, the facility had not called an ambulance to transport the resident to the hospital in a timely manner, the facility had not contacted the physician or family member within a timely manner and a staff member went back to bed after after a resident fell out of bed were substantiated (See Tags Y050, Y850 and Y992). The investigation into the allegations included: Observation of resident's physical appearance and staff to resident interactions for seven residents. Interviews were conducted with five residents, two Caregivers, the Owner, hospice agency Director of Nursing and a family member. Review of seven medical records including the resident of concern. Review of the Fall Protocol Policy, the Incident Reporting Policy and the Caregiver Training Policy. The facility received a grade of D. The findings and conclusions of any investigation by the Division of Public and	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: CRISTINA P ABU DAYYEH | Title: Owner/Manager | Date: 07/02/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified. Deficiencies unrelated to the allegations were also identified at the time of the survey and include the following:			
0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, document review, record review and interview, the Administrator failed to provide oversight and direction for the employees to provide the necessary needed services and protective supervision. Findings include: Please see TAGs Y850 and Y992. Severity: 2 Scope: 3	0050	1. The Administrator emphasized to the facility staff to render high standard of care. 2. The Administrator visits the place 4 times a week to ensure staff are well trained in rendering services to the residents. 3. The administrator conducts training and review regarding policies and procedures i.e Emergency protocols, etc., to all staff and constant reminders to every details of the staff's job descriptions. 4. The Administrator is responsible that facility is compliant with the regulations to ensure resident's safety by conducting staff review and training at least once a month and as needed. 5. 5/3/19	06/23/2019

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0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on observation and interview, the facility failed to ensure a current staff schedule was posted in a common area. Findings include: On 05/02/19 at 2:20 PM, the staff schedule posted on the wall was for April 2019. Caregiver #4 indicated 3 of 6 staff members listed on the schedule were no longer employed at the facility. Caregiver #3 and #4 had been employed for several months and were not listed as staff on the schedule. Caregiver #4 acknowledged the May 2019 staff schedule was not posted and indicated it should have been posted. Severity: 1 Scope: 3	0088	1. Updated staff schedule had been posted. 2. Monthly Staff Schedule has to be posted on time every 1st of the month and update as needed; when staffing changes. 3. The in charge of the facility will ensure that timely posting of the schedule on or before beginning of each month. 4. The facility owner/manager is responsible to ensure timely posting of the schedule by adding list it to routine checklist. 5. 05/03/2019	06/23/2019
0102 SS= F	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and record review, the facility failed to ensure 2 of 4 sampled employees (Employee #3 and Employee #4) met the requirements concerning pre-employment physical examinations. Findings include: Employee #3 (E3) and Employee #4 (E4) On 04/30/19 in the afternoon, E3 was observed cooking lunch for the residents. In the afternoon, E3 was observed pushing a resident in a wheelchair to the living room area. On 04/30/19 in the afternoon, E4 was	0102	1. Employees #3 and #4 employment were terminated as of 5/03/2019 2. Facility requires all employees to submit TB test and other necessary paper works upon hiring. 3. Facility employee checklist had been used to complete needed requirements upon employment. 4. The facility owner who's responsible in hiring staff has also the responsibility to ensure complete requirements are submitted by the employees before start of work, and the facility Administrator will ensure compliance by reviewing the staff file with the use of Employee file checklist every visit at the facility. 5. 05/02/2019	06/23/2019

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	observed pushing a resident in a wheelchair to the living room area and assisting a resident with oxygen. On 04/30/19 in the afternoon, E3 indicated E3 was a Caregiver and was hired two months ago. E3 indicated E3 assisted residents with mobility, transferred residents from bed to wheelchair and changed residents who were incontinent of bowel and bladder. On 04/30/19 in the afternoon, E4 indicated E4 was a Caregiver and was hired four months ago. E4 indicated E4 assisted residents with mobility, transferred residents from bed to wheelchair and changed residents who were incontinent of bowel and bladder. Review of personnel records lacked documented evidence E3 and E4 had completed a pre-employment physical examination. On 04/30/19 in the afternoon, E3 and E4 acknowledged they had not completed a physical examination prior to working at the facility. On 05/01/19 at 3:00 PM in a telephone interview, the Owner indicated E3 and E4 were new hires and had worked at the facility for one month. The Owner explained E3 and E4 had completed a pre-employment physical examination. The Owner indicated the physical examination for E3 and E4 would be submitted to the State entity by close of business on 05/09/19. The physical examinations for E3 and E4, provided by the Owner on 05/09/19, were undated. The documentation submitted by the Owner lacked evidence E3 and E4 had a pre-employment physical examination. Severity: 2 Scope: 3			
0104 SS= F	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on interview and record review, the facility failed to	0104	1. Employees #3 & #4 terminated effective 05/03/2019 2. The facility requires personnel background check when hiring. 3. The facility manager/owner who is responsible in hiring employees has to comply with the employee requirement checklist when hiring employees before start date of work. 4. The facility owner is responsible to ensure that the facility is compliant with the	05/03/2019

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	ensure 2 of 4 sampled employees (Employee #3 and Employee #4) met the background check requirements of Nevada Revised Statute (NRS) 449.124. Findings include: Employee #3 (E3) and Employee #4 (E4) On 04/30/19 in the afternoon, E3 was observed cooking lunch for the residents. In the afternoon, E3 was observed pushing a resident in a wheelchair to the living room area. On 04/30/19 in the afternoon, E4 was observed pushing a resident in a wheelchair to the living room area and assisting a resident with oxygen. On 04/30/19 in the afternoon, E3 indicated E3 was a Caregiver and was hired two months ago. E3 indicated E3 assisted residents with mobility, transferred residents from bed to wheelchair and changed residents who were incontinent of bowel and bladder. On 04/30/19 in the afternoon, E4 indicated E4 was a Caregiver and was hired four months ago. E4 indicated E4 assisted residents with mobility, transferred residents from bed to wheelchair and changed residents who were incontinent of bowel and bladder. Review of personnel records lacked documented evidence E3 and E4 had a background check either by a Nevada Automated Background Check System (NABS) Clearance Letter, a Federal Bureau of Investigation (FBI) clearance letter or a State background clearance letter. The employee files lacked documented evidence of finger printing. On 04/30/19 in the afternoon, the facility's NABS account lacked documented evidence of E3 and E4 being entered and cleared. On 04/30/19 in the afternoon, E3 and E4 acknowledged they had not completed a background check or finger printing prior to working at the facility. On 05/01/19 at 3:00 PM in a telephone interview, the Owner indicated E3 and E4 were new hires and had worked at the facility for one month. The Owner explained E3 and E4 had not completed a background check or fingerprinting because two other employees quit working at the facility		regulations in hiring employees and the facility Administrator will review files by the use of the Employee File Checklist every visit at the facility. 05/03/2019	

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	unexpectedly. The Owner acknowledged E3 and E4 had not completed a background check or fingerprinting prior to working at the facility. Severity: 2 Scope: 3			
0276 SS= D	Service of Food-Nutritious Meals;Frequency - NAC 449.2175 Service of food 7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are not prohibited by their physicians from eating between meals. Inspector Comments: Based on observation and interview, the facility failed to ensure 1 of 7 residents received a snack upon request (Resident #3). Findings include: Resident #3 (R3) R3 was admitted on 03/16/17, with diagnoses including dementia and hypertension. On 05/02/19, at 11:30 AM, R3 told Caregiver #3 she was hungry. The Caregiver told R3 in a little bit. R3 told the Caregiver once again R3 was hungry and the Caregiver reported it was almost lunch time. R3 raised her voice and told the Caregiver again R3 was hungry and the Caregiver laughed. The surveyor had to request the Caregiver to provide R3 with a snack before lunch. On 05/02/19 at 11:30 AM, R3 made noises at the surveyor when asked questions about snacks. Severity: 2 Scope: 1	0276	1. R3 is provided with meals and snacks as desired in an appropriate portion to prevent overweight. 2. The facility shall impose the mealtime hours as scheduled and upon request of the residents. 3. The facility has mealtime scheduled and is posted on the bulletin board. 4. The facility owner is responsible to ensure compliance on food service by strictly following the scheduled mealtimes everyday. 5. 05/03/2019	05/03/2019

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0592 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (c) The residents are treated with respect and dignity; Inspector Comments: Based on observation and interview, the facility failed to ensure 1 of 7 residents were given access to a telephone (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 12/07/18, with diagnoses including diabetes, hypertension and acute kidney injury. On 05/02/19 at 11:15 AM, R2 asked Caregiver #3 where R2's family was with a concerned voice and the Caregiver indicated R2's family was coming. At 11:45 AM, R2 repeated over and over that something was wrong and wanted to speak with R2's family. The Caregiver #3 repeated R2's family was coming. At 1:00 PM, R2 was screaming something is wrong and I need to talk to my family. Caregiver #3 repeated R2's family was coming. The surveyor asked Caregiver #3 if R2's family was coming today and the Caregiver reported he did not know. The Caregiver did not know where R2's family's phone number was and indicated Caregiver #4 did but did not know where Caregiver #4 was. At 2:05 PM, R2 was crying and had tears coming down R2's face. R2 reported R2 felt something was wrong and wanted to call her family. R2 lifted up R2's hands and indicated she could not call because R2's fingers did not work and the Caregiver would not call for R2. At 2:05 PM, Caregiver #3 did not know where to find a family's phone number in a resident file. Caregiver #4 had to assist Caregiver #3 in calling R2's family member. Severity: 2 Scope: 1	0592	1. Resident #2 had a diagnosis of anxiety. She's prescribed Lorazepam 0.5mg 3times a day. R2 is always looking for her "family" and the daughter is aware of her anxiety episodes and daughter was encouraged to call and/or visit more often. 2. The facility staffs were instructed to call family every time R2 becomes anxious. 3. The facility staffs were given instructions to call family when being asked by any residents. 4. The facility owner is responsible to ensure resident's are treated with high respect and maintain dignity by constant communication with residents and family for any concerns they have. 5. 05/03/2019	06/23/2019

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0702 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 3. The administrator of a residential facility shall ensure that the caregivers who may be required to administer oxygen have demonstrated the ability to operate properly the equipment used to administer oxygen. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure a Caregiver was able to demonstrate how to properly operate 1 of 7 sampled resident's (Resident #2) oxygen concentrator. Findings include: R2 was admitted on 12/07/18, with diagnoses including diabetes and hypertension. R2 received hospice services. A physician's order dated 03/27/19, documented oxygen via nasal cannula at 2 liters per minute (LPM) as needed during the day. On 04/30/19 in the afternoon, R2 was observed being administered oxygen via nasal cannula. The oxygen concentrator read R4 was receiving oxygen at 1 LPM. On 04/30/19 in the afternoon, a Caregiver was unaware how many LPM's R2 was supposed to be receiving. The Caregiver was unaware how to locate the physician's order for oxygen to verify LPM's. The Caregiver was unable to demonstrate how to adjust/change the LPM's on the oxygen concentrator. The Caregiver indicated the Caregiver had not received training in oxygen administration. On 05/01/19 at 3:00 PM during a telephone interview, the Owner indicated Caregivers were supposed to be trained on how to administer oxygen to residents who required administration of oxygen. The Owner indicated the Caregiver's judgement and assessment was not to be trusted. E3's training records lacked documented evidence E3 had completed training on oxygen administration. Severity: 2 Scope: 1	0702	1. All the facility staffs were given training on "oxygen administration" by the facility owner, hospice RN and from the people who delivers O2 concentrator as part of their delivery procedure. 2. All Facility staffs were asked to do return demonstration on every procedure that is tendered to the residents 9like 02 administration) after given proper training to ensure understanding of the given instructions. 3. The facility owner will monitor performance skills of every staff administering procedures. 4. The facility owner is responsible to ensure facility is compliant with Oxygen administration by monitoring skills and knowledge of every staff administering procedure by return demonstration. 5. 05/03/2019	05/03/2019
0850 SS= G	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after	0850	1. Due to the incident happened to R1, Employee#3 had not acted promptly on	05/03/2019

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	illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 1. If a resident of a residential facility becomes ill or is injured, the resident ' s physician and a member of the resident ' s family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident ' s physician is not available; and (b) Request emergency services when such services are necessary. Inspector Comments: Based on observation, interview, record review and documentation review, the facility failed to ensure 1) the physician, hospice nurse and family member were notified and pain was assessed at the time 1 of 7 sampled residents (Resident #1) sustained a fall with injury; and 2) a physician was notified after 1 of 7 sampled resident's reported a skin condition (Resident #4). Findings include: Resident #1 (R1) R1 was admitted on 09/08/18 with diagnoses including advanced dementia. A Needs Assessment dated 02/07/19, documented R1 had severe dementia and required protective supervision. A hospice plan of care dated 02/08/19, documented R1 had a history of falls within the last three months due to possible abuse and neglect. The plan of care was to monitor group home staff to avoid abuse and neglect. A hospice plan of care dated 02/14/19, documented R1 had poor coordination and weakness and was at risk for falls. A hospice plan of care dated 02/18/19, documented R1 had anxiety and confusion. A hospice plan of care dated 03/19/19, documented R1 had a fall due to increased weakness. The plan of care indicated R1 was at risk for falls and should have been provided ongoing assessment of physical, cognitive and environmental factors. An Incident Report dated 04/01/19 indicated a Caregiver found R1 laying on		facility policy related to the incident, thus resulted to termination of R3 employment. R4 has a scheduled appointment to see her primary physician regarding her complain of itching on the leg on 06/14/2019 at 3pm. No rash had been noted at this time. 2. The facility staffs were given training on immediate reporting on any change of condition, illness or injuries of a resident to resident's family and primary physician and follow the facility policies. If resident has a change of condition, depending on the severity, must be assessed and monitored and provided appropriate actions, until condition is improved or resolved 3. The facility staffs shall be given training and review with injury related to fall and other emergencies by following the process of the Emergency Protocols by dialing 911 (perform CPR if needed), call Administrator immediately and will call family immediately. Once paramedics picked up the resident from the facility, incident report must be filled up. 4. The facility Administrator is responsible to ensure facility staffs are compliant with the policies and procedures by giving training and review instructions at least every month and as needed and ensure that staffs can demonstrate understanding after each training. 05/03/2019	

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	the floor around 3:00 AM. The Caregiver checked for cuts and bleeding and R1 had none. The Caregiver indicated R1 was sleeping and it was just two Caregivers who would not have been able to put R1 back to bed as R1 was heavy. The Caregiver decided to let R1 continue sleeping and wait until R1 woke up to contact Hospice and the Owner. At 7:30 AM, R1 was still asleep and the Certified Nursing Assistant (CNA) arrived after 7:30 AM. A hospice nursing progress note dated 04/01/19, documented a hospice Certified Nursing Assistant (CNA) contacted the Director of Nursing (DON) at 7:45 AM. The CNA reported R1 had been on the floor since 3:00 AM when the CNA arrived. The CNA spoke to a Caregiver at the facility at the time and the Caregiver reported R1 fell around 3:00 AM, but because R1 was heavy the Caregiver decided to leave R1 on the floor. The progress note documented R1 had a possible fracture to the left hip or leg and was in severe pain. The progress note indicated R1's vital signs were taken and R1's blood pressure was very high at 191/128. R1 was guarding the left side and yelled on touch. Lisinopril 5 milligrams (mg) was ordered immediately for one dose. Norco 7.5/350 mg one tablet was ordered immediately and every four hours thereafter. Per the progress note, a physician's order was obtained to send R1 to the emergency room (ER) for further evaluation, but the facility did not allow the CNA to phone emergency number. A hospice nursing progress note dated 04/01/19 at 2:00 PM, documented R1 was admitted to the hospital. The DON called the hospital's ER department to check on R1's status. The DON was informed R1 had a left hip fracture and was going to be admitted to the hospital. A History and Physical dated 04/01/19, documented R1 came to the emergency department with a left sided hip fracture. R1's left leg was externally rotated. An Emergency Department (ED) discharge summary dated			

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SPRING VALLEY ALZ CARE CENTER	**6428 CRYSTAL DEW DRIVE, LAS VEGAS, NEVADA ,89118**

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	04/01/19, documented R1 was found on the side of the bed sometime in the morning with obvious deformity. R1 broke the left hip. The ED report documented R1 was in pain. A consultation report dated 04/02/19, documented R1 had a physical examination completed. Any range of motion produced pain. R1's medical record was unavailable at the time of the survey. There was no documented evidence R1 had been assessed for pain after R1 had fallen. There was no documented evidence the physician, hospice agency nurse or R1's family member had been notified at the time R1 had fallen on 04/01/19. On 04/30/19 in the morning, two Caregivers indicated if a resident had an unwitnessed fall, pain was assessed and documented. The Caregivers indicated the procedure was to ask the resident where the pain was located and how bad the pain felt to determine whether the incident was an emergency. The Caregivers indicated the Owner was called immediately. The Caregivers indicated the Owner made the decision about calling the resident's physician and family member. The Caregivers indicated the physician and the resident's family member were supposed to be notified at the time the fall was discovered. One of the Caregivers indicated on the night of 04/01/19, R1 fell out of bed three times. The Caregiver indicated the first time R1 fell out of bed, R1 fell to the ground and the Caregiver was able to get R1 back into bed. The Caregiver indicated R1 was not in pain after the fall. The Caregiver had not notified the hospice agency nurse, the physician or R1's family member because the Caregiver was able to get R1 back to bed. The Caregiver had not contacted the Owner regarding the first fall. The second time R1 fell out of bed, the Caregiver was able to get R1 back into bed. The Caregiver indicated R1 was not in pain after the second fall out of bed. The Caregiver had not notified the hospice agency nurse, the physician or R1's family member because the Caregiver was able to			

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	get R1 back to bed. The Caregiver had not contacted the Owner regarding the second fall. The third time R1 fell out of bed, it was around 3:00 AM and the Caregiver noticed R1 was asleep on the ground. The Caregiver gave R1 a pillow and a blanket and left R1 to sleep on the ground. The Caregiver explained R1 was not assessed for pain after the third fall because the Caregiver had not wanted to wake R1. The Caregiver was unaware whether R1 was asleep or unconscious because the Caregiver had not assessed R1 for pain. The Caregiver indicated being unaware if R1 had sustained any injuries because the Caregiver had not asked R1 after the third fall. The Caregiver had not notified the hospice agency nurse, the physician or R1's family member because the Caregiver knew the CNA was coming to visit R1 the next morning. The Caregiver had not contacted the Owner regarding the third fall. On 05/01/19 at 3:00 PM during a telephone interview, the Owner indicated the standard procedure when a resident fell, was to assess for injuries and pain and contact emergency as needed. The Owner explained the Caregivers had been instructed to contact the Owner if an incident occurred in the night so the Owner could notify the physician and family member as required. The Owner indicated on the night of 04/01/19, the Caregivers had not attempted to contact the Owner to ask for help. The Owner indicated the Caregiver had not assessed R1 for injuries and pain and had not notified the hospice agency nurse, the physician and R1's family member. The Owner indicated the expectation was for the Caregiver to have checked R1, even if R1 was asleep, to ensure R1 was alright. The Owner indicated the Owner did not trust the Caregivers' judgement. On 05/03/19 at 8:00 AM, the DON from R1's hospice agency indicated on 04/01/19, a CNA informed the DON that R1 had fallen around 3:00 AM and had been lying on the ground until the CNA			

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	arrived at 7:45 AM. The DON indicated R1 had not been assessed for pain by the Caregivers. The DON indicated the CNA assessed R1 for pain when the CNA arrived at the facility at 7:45 AM. The DON indicated the DON went to the facility and observed R1. The DON indicated R1 was in excruciating pain as observed by R1 screaming, yelling and frowning. When the DON arrived, there were two Caregivers and the Owner had not arrived yet. The DON indicated the Caregivers picked R1 up and put R1 back into bed. The DON indicated moving R1 back to bed after falling made R1's injuries worse. The DON indicated the facility should have contacted 911. The DON confirmed the Caregiver at the facility had not notified the hospice agency or the physician of R1's fall when it occurred. The DON confirmed the first time the hospice agency was aware of the incident was at 7:45 AM on 04/01/19. The DON indicated the Caregiver had not notified R1's family member. The DON explained hospice staff notified R1's family member when hospice staff arrived at the facility and found out R1 had fallen. A facility policy entitled Emergency Protocol (undated), documented in the event of a resident emergency involving falling and unable to move freely without pain, the facility staff should have dialed 911 and if resident was in hospice, call hospice instead. The staff were to contact the Administrator and/or Owner and family member immediately. Resident #4 (R4) R4 was admitted on 08/24/17 with diagnoses including history of scabies. On 04/30/19 in the morning, R4's hands were inside the front right side of R4's pants. R4 indicated R4's legs had a rash and had been itching for over 2 months. R4 indicated R4 had not received medication for the itching. R4 indicated R4 had not seen a physician in over a year. R4 indicated R4 told the Caregiver staff about the itch. On 04/30/19 in the morning, R4 informed a Caregiver R4's legs itched. The surveyor informed the			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	Caregiver R4's legs had been itching for over two months. The Caregiver was unaware R4 had been itching. The Caregiver was unaware if R4 had been seen by a physician. The Caregiver indicated the Owner took care of physician appointments. On 04/30/19 in the afternoon, the Caregiver had not notified a physician of the report R4 had made regarding the itching and rash on R4's legs. The Caregiver indicated the Owner was responsible for contacting the physician. On 05/01/19 at 3:00 PM during a telephone interview, the Owner indicated the Owner was unaware R4 had a rash and was itching on R4's legs. The Owner indicated the standard procedure when a resident had a new illness or injury, was to notify the physician. The Owner acknowledged a physician had not been notified of the itching and rash on R4's legs. Severity: 3 Scope: 1 Complaint #NV00056887			

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident received a physical examination upon admission for 1 of 7 residents (Resident #8). Findings include: Resident #8 (R8) R8 was admitted approximately on 04/17/19, with diagnoses unknown. R8's file lacked documented evidence of an admission date and a diagnosis. On 05/02/19, at 11:00 AM, R8's file lacked documented evidence of a physical examination. The Caregiver was unable to provide a physical examination for R8 and indicated R8 had only been at the facility for two weeks. Severity: 2 Scope: 1	0859	1. R8 was admitted at the facility on 04/16/19. Upon admission, the resident had a copy of the latest H&P dated 04/08/2019. 2. The facility requires written records of history and physical examination upon admission of a resident to the facility. 3. The facility staff admitting the new resident will use the facility resident file checklist to ensure completion of the required documents for new resident. 4. The facility manager/owner is responsible to ensure complete resident's file by coordinating with resident's family and case worker from the discharging facility to provide the required paper works before they discharge the resident to our facility, and review files as soon as the resident is admitted to our facility. 5. 05/03/2019	06/23/2019

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident signed an ultimate user agreement upon admission for 1 of 7 residents (Resident #8). Findings include: Resident #8 (R8) R8 was admitted approximately on 04/17/19, with diagnoses unknown. R8's file lacked documented evidence of an admission date and a diagnosis. On 05/02/19, at 11:00 AM, R8's file lacked documented evidence of an ultimate user agreement. The Caregiver was unable to provide an ultimate user agreement for R8 and indicated R8 had only been at the facility for two weeks. Severity: 2 Scope: 1	0876	1. R8 admitted in the evening of 4/16/2019. Admission record had been completed. 2. The facility admission requirements of a resident had been completed in a timely manner. 3. The facility admitting staff will complete the necessary paper works upon admission by the use of "Resident File Checklist" 4. The facility manager/owner is responsible to ensure resident records are complete upon admission by coordinating with the responsible part and case worker of the discharging facility to provide required records of the resident upon admission to the group home facility. 05/03/2019	06/23/2019
0878 SS= F	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions	0878	1. R2 Lisinopril is still a current order. R2 Lorazepam order has been changed on 04/01/19..order uploaded. R2 Douneb has been ordered 3 times a day on 12/07/18 as noted in the MAR..order uploaded. R2 Ondansetron order was an order received from the upon admission but didn't renew order when admitted on hospice. Medication removed from the resident's medication box. R2 Hyosyamin was delivered 5/9/19 R2 Loperamide order was delivered from	05/06/2019

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	of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on interview and record review, the facility failed to ensure 1) medications and physician orders were available for 7 of 7 sampled residents (Resident #2, #3, #4, #5, #6, #7 and #8) and 2) oxygen was administered per the physician's order for 1 of 7 sampled residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 12/07/18, with diagnoses including diabetes, hypertension and acute kidney injury. A physician's order dated 12/06/18, documented Lisinopril 20 milligrams (mg). Take one tablet by mouth daily. On 05/02/19 at 12:30 PM, the surveyor was		the pharmacy as the hospice RN is responsible to notify the pharmacy for change of orders .not called to the pharmacy as discontinued by the hospice RN as of 4/1/19 R3 Loperamide has been discontinued on 4/1/19. order uploaded R4 Oxybutinin medication was refilled from the pharmacy on 05/07/19 R4 Alprazolam medication awaiting renewal of prescription from the primary physician for review. Appointment on June 14 at 3pm. Alprazolam delivered 6/17/19 R5 Escitalopram has been refilled on 5/6/19 R5 Lisinopril has been refilled on 05/6/19 R5 Risperidone has been refilled on 5/6/19 R5 Quetiapine has been refilled on 5/6/19 R6 Aspirin was bought OTC on 5/3/19 R6 Folic acid was bought OTC on 5/3/19 R6 Alprazolam awaiting refill order from the physician. Refilled 6/17/19 R7 Aspirin bought OTC on 5/3/19 R7 D3 bought OTC on 5/3/19 Caregiver#3 terminated employment effective immediately. 2. Staff in charge of medication has been given reinforcement training regarding facility policy and procedure on medication administration including Oxygen administration given by the Administrator. 3. The facility owner will continue to monitor daily if personnel in charge of medication is done appropriately by close observation on the staff when preparing and administering medications and oxygen administration to ensure correct procedure. 4. The facility owner is responsible to ensure facility compliance with the regulation by constant supervision of staffs responsible in administering medications including oxygen administration.	

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	unable to locate the medication in R2's medication bin. The Caregiver indicated the medication was discontinued the week before. The Caregiver reported the nurse verbally discontinued the medication and did not provide a discontinue order. After this discussion, the refill for Lisinopril was found in R2's medication bin. There was no discontinued order for the medication and the Caregiver was unable to provide one. On 05/02/19 at 12:30 PM, the Medication Administration Record (MAR) documented Lorazepam 0.5 mg. Take one tablet by mouth every eight hours. The medication label documented Lorazepam 0.5 mg. Take one tablet by mouth every eight hours as needed. R2's file lacked documented evidence of a physician's order and there was no change order sticker on the medication bottle. The medication did not indicate what Lorazepam was prescribed for. The Caregiver indicated the medication was routine given three times a day. The Caregiver was unable to provide a change order for the medication. A physician's order dated 12/06/18, documented Duoneb 0.5/2.5 (3 mg). Inhale one vial via nebulizer four times a day. The MAR documented three times a day and the medication label documented two times a day. On 05/02/19 at 12:30 PM, R2's file lacked documented evidence of a change order for Duoneb and there was no change order sticker on the medication box. The Caregiver verified the discrepancies and was unable to provide an order. The Caregiver could not explain why the MAR, the medication label and the order did not match. On 05/02/19 at 12:30 PM, R2's medication bin contained Ondansetron 4 mg. Take one tablet by mouth every six hours as needed for nausea and vomiting. The medication was not documented on the MAR and R2's file lacked documented evidence of a physician's order. The Caregiver was unable to provide a physician's order. The Caregiver verified the medication was not on the MAR and did not know if this was a		5. 5/6/19	

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	current medication. A physician's order dated 12/06/18, and the MAR documented Hyosyamine 0.125 mg. Take one tablet by mouth under the tongue every six hours as needed for incontinence. On 05/02/19 at 12:30 PM, R2's Hyosyamine was not on site. The Caregiver was unaware R2 was prescribed Hyosyamine and could not provide a discontinued order. On 05/02/19 at 12:30 PM, R2's medication bin contained Loperimide 2 mg. Take one tablet by mouth every eight hours as needed. The medication was not documented on the MAR and R2's file lacked documented evidence of a physician's order. The medication label did not indicate what Loperimide was prescribed for. The Caregiver was unable to provide a physician's order. The Caregiver verified the medication was not on the MAR and did not know if this was a current medication. Resident #3 (R3) R3 was admitted on 03/16/17, with diagnoses including dementia and hypertension. On 05/02/19 at 12:30 PM, R2's medication bin contained Loperimide 2 mg. Take one tablet by mouth three times a day as needed for diarrhea. The medication was not documented on the MAR and R2's file lacked documented evidence of a physician's order. The Caregiver was unable to provide a physician's order. The Caregiver verified the medication was not on the MAR and did not know why the medication was not on the MAR. Resident #4 (R4) R4 was admitted on 08/24/17, with diagnoses including Alzheimer's disease, hypertension, anemia and osteoarthritis. A physician's order dated 08/22/17, documented Oxybutinin Extended Release 5 mg. Take one tablet by mouth every day. The medication was not on site. The medication bottle was empty in R4's medication bin dated 03/14/19. A physician's order dated 08/23/17, documented Alprazolam 0.5 mg. Take one tablet by mouth every eight hours as needed for anxiety. The medication was not on site. On 05/02/19 at 12:30 PM, the			

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	Caregiver indicated the Oxybutinin and the Alprazolam had not been ordered and was unable to report how long the medication had been gone. On 05/02/19 at 1:05 PM, R4 was not aware any medications were missing and felt good. Resident #5 (R5) R5 was admitted on 11/09/17, with diagnoses including dementia. A physician's order dated 12/21/16, documented Escitalopram 5 mg. Take one tablet by mouth every day. The medication was not on site. The medication bottle was empty in R5's medication bin and the medication label was dated 02/04/19. A physician's order dated 12/21/16, documented Lisinopril 20 mg. Take one tablet by mouth every day. The medication was not on site. The medication bottle was empty in R5's medication bin and the label was dated 02/05/19. A physician's order dated 11/17/17, documented Risperidone 0.25 mg. Take one tablet by mouth twice a day. The medication was not on site. The medication bottle was empty in R5's medication bin and the label was dated 12/10/18. A physician's order dated 11/17/17, documented Quetiapine 25 mg. Take one tablet by mouth every night at bedtime as needed for agitation, aggression or restlessness. The medication was not on site. The medication bottle was empty in R5's medication bin dated 10/12/18. On 05/02/19 at 12:30 PM, the Caregiver the indicated R5's medications had not been ordered and was unable to report how long the medication had been gone. 05/02/19 at 1:00 PM, R5 was unable to conduct an interview. Resident #6 (R6) R6 was admitted on 09/28/17, with diagnoses including chronic kidney disease and coronary artery disease. A physician's order dated 08/29/18, documented Aspirin 81 mg. Take one tablet by mouth every day. The medication was not on site. A physician's order dated 05/14/18, documented Folic Acid 800 mg. Take one tablet by mouth every day. The medication was not on site. A physician's order dated 01/12/18,			

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	documented Alprazolam 0.25 mg. Take one tablet by mouth every day as needed for agitation. The medication was not on site. On 05/02/19 at 12:30 PM, the Caregiver the indicated R6's medications had not been ordered and was unable to report how long the medication had been gone. 05/02/19 at 1:00 PM, R6 was unaware any medications were missing and felt good. Resident #7 (R7) R6 was admitted on 09/09/16, with diagnoses including dementia. A physician's order dated 10/31/17, documented Aspirin 81 mg. Take one tablet by mouth every day. The medication bottle had one pill left in it and the medication label was dated 07/02/18. On 05/02/19 at 12:30 PM, R2's medication bin contained an empty bottle of Vitamin D3 1,000 unit. Take one tablet by mouth every day. R7's file lacked documented evidence of a physician's order. The medication was not on site and the medication label was dated 01/08/19. On 05/02/19 at 12:30 PM, the Caregiver the indicated R7's medications had not been ordered and was unable to report how long the medication had been gone. the Caregiver indicated R7 had not received the Aspirin that morning even though there was a pill in the medication bottle. 05/02/19 at 1:00 PM, R7 indicated R7 did not take medications and felt good. Resident #8 (R8) R8 was admitted approximately on 04/17/19, with diagnoses unknown. R8's file lacked documented evidence of an admission date and a diagnosis. On 05/02/19 at 12:30 PM, R8's file lacked documented evidence of physician orders for all medications. R8's medication bin contained a bottle of Vitamin D3 2,000 unit and a bottle of Aspirin 81 mg. The medications were not listed on the MAR and R8's file did not contain discontinued orders for these medications. On 05/02/19 at 12:30 PM, the Caregiver was unable to provide physician orders for R8's medications and could not provide an explanation as to why the two medications were not listed on the MAR. Severity: 2 Scope: 3 R2 was admitted			

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	on 12/07/18, with diagnoses including diabetes and hypertension. R2 received hospice services. A physician's order dated 03/27/19, documented oxygen via nasal cannula at 2 liters per minute (LPM) as needed during the day. On 04/30/19 in the afternoon, R2 was observed being administered oxygen via nasal cannula. The oxygen concentrator read R4 was receiving oxygen at 1 LPM. On 04/30/19 in the afternoon, a Caregiver was unaware how many LPM's R2 was supposed to be receiving. The Caregiver was unaware how to locate the physician's order for oxygen to verify LPM's. On 05/01/19 at 3:00 PM during a telephone interview, the Owner indicated the resident was supposed to be administered oxygen per the physician's order. The Owner recalled the physician's order was 2 LPM via nasal cannula as needed during the day. On 05/09/19 at 9:45 AM, the hospice agency Director of Nursing (DON) confirmed R2's order for oxygen was 2 LPM via nasal cannula as needed during the day. Severity: 2 Scope: 3			

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0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were destroyed after a resident had moved out (Resident #1). Findings include: On 05/02/19 at 1:30 PM, Resident #1 had a bin with six medications in it stored in the medication cabinet. The medications included Vitamin D3, Risperidone, Escitalopram, Levothyroxine and two bottles of Divalproex. The medication cabinet also included a bottle of Aspirin with the prescribed person's name ripped off. Caregiver #3 indicated Resident #1 had moved out a month ago. The Caregiver indicated the medications should have been destroyed and did not know why the bottle of Aspirin was in the cabinet. Severity: 2 Scope: 1	0885	1. R1 medications had been disposed of properly. Medication destruction record uploaded 2. Once resident is discharge from the facility, any leftover medications shall be destructed and disposed them as per policy and procedure by the caregiver in charge and cosigned by second staff of the facility. 3. The staff in charge of the medication record has to check medication cabinet on any presence of medications that belong to a discharge resident and other medications that are discontinued. 4. Facility owner is responsible that all medications that belongs to a discharge resident shall be immediately disposed of accordingly. 5. 05/2/19	06/23/2019
0895 SS= F	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or	0895	1. R2,R3,R4,R5,R6,R7 Medication Administration Records had been signed accordingly. Employee #3 who was responsible on medication administration had been terminated employment effective immediately. 2. The facility staffs were given re-enforcement training on proper medication administration procedure and they were required to do a return demonstration to ensure understanding of the procedure on medication administration. 3. The facility owner will conduct a daily	06/23/2019

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	otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure the Medication Administration Record (MAR) was complete for 7 of 7 residents (Resident #2, #3, #4, #5, #6, #7 and #8). Findings include: On 05/02/19 at 12:30 PM, the MAR was not on-site. The Caregiver had to go across the street to the owner's other licensed facility to get the MAR. Resident #2 (R2) R2 was admitted on 12/07/18, with diagnoses including diabetes, hypertension and acute kidney injury. On 05/02/19 at 12:30 PM, a review of R2's MAR revealed medications had not been documented as given since 04/25/19. There was lack of documentation a May 2019 MAR had been created. Resident #3 (R3) R3 was admitted on 03/16/17, with diagnoses including dementia and hypertension. On 05/02/19 at 12:30 PM, a review of R3's MAR revealed medications had not been documented as given since 04/25/19. There was lack of documentation a May 2019 MAR had been created. Resident #4 (R4) R4 was admitted on 08/24/17, with diagnoses including Alzheimer's disease, hypertension, anemia and osteoarthritis. On 05/02/19 at 12:30 PM, a review of R4's MAR revealed medications had not been documented as given since 04/25/19. There was lack of documentation a May 2019 MAR had been created. Resident #5 (R5) R5 was admitted on 11/09/17, with diagnoses including dementia. On 05/02/19 at 12:30 PM, a review of R5's MAR revealed medications had not been documented as given since 04/25/19. There was lack of documentation a May 2019 MAR had been created. Resident #6 (R6) R6 was admitted on 09/28/17, with diagnoses including chronic kidney disease, and coronary artery		check and observation at the facility to ensure staffs are capable of delivering appropriate care to all residents of the facility. 4. The administrator is responsible to ensure that facility is compliant with the regulations by conducting a staff training on a regular basis to ensure capabilities of all staffs in carrying out proper care to every resident of the facility. 5/3/19	

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	disease. On 05/02/19 at 12:30 PM, a review of R6's MAR revealed medications had not been documented as given since 04/25/19. There was lack of documentation a May 2019 MAR had been created. Resident #7 (R7) R6 was admitted on 09/09/16, with diagnoses including dementia. On 05/02/19 at 12:30 PM, a review of R7's MAR revealed medications had not been documented as given since 04/25/19. There was lack of documentation a May 2019 MAR had been created. Resident #8 (R8) R8 was admitted approximately on 04/17/19, with an unknown diagnosis. The resident's file lacked documented of an admission date and diagnosis. On 05/02/19 at 12:30 PM, a review of R8's MAR revealed medications had not been documented as given since 04/25/19. On 05/02/19 at 12:30 PM, the Caregiver indicated the Owner had brought the MAR to the facility across the street and did not know why. The Caregiver did not ask the Owner for the MAR but reported the resident had received the medications. Severity: 2 Scope: 3			
0905 SS= D	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his or her need for the medication; (b) The determination of the resident ' s need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on record	0905	1. R2 and R3 Tylenol order had been reviewed by the Hospice doctor and added parameters of fever temperature when medication is required to be administered. 2. Any indications of PRN medications for fever should have a written parameters as required per regulations. 3. Facility staff who received an order from the doctor regarding antipyretic medication should verify from the ordering physician if parameters not specified. 4. The facility owner is responsible to ensure compliance on correct medication administration by checking every new orders from the doctor before being written on the Medication Administration record. 5. 5/3/19	06/23/2019

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	review and interview, the facility failed to ensure an order was clarified for an as needed medication for 2 of 7 residents (Resident #2 and #3). Findings include: Resident #2 (R2) R2 was admitted on 12/07/18, with diagnoses including diabetes, hypertension and acute kidney injury. On 05/02/19 at 12:30 PM, R2's medication bin contained Tylenol 500 milligrams (mg). Take one tablet by mouth every six hours as needed for pain or fever. The medication did not document a temperature to give Tylenol for fever and the Caregiver did not know when to give the medication. R2's file lacked a physician's order and the Caregiver was unable to provide one. Resident #3 (R3) R3 was admitted on 03/16/17, with diagnoses including dementia and hypertension. On 05/02/19 at 12:30 PM, R2's medication bin contained Tylenol 500 milligrams (mg). Take one tablet by mouth every six hours as needed for pain or fever. The medication did not document a temperature to give Tylenol for fever and the Caregiver did not know when to give the medication. R2's file lacked a physician's order and the Caregiver was unable to provide one. Severity: 2 Scope: 2			

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0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure a resident received a tuberculosis (TB) test upon admission for 1 of 7 residents (Resident #8). Findings include: Resident #8 (R8) R8 was admitted approximately on 04/17/19, with diagnoses unknown. R8's file lacked documented evidence of an admission date and a diagnosis. On 05/02/19, at 11:00 AM, R8's file lacked documented evidence of a two step TB test. The Caregiver was unable to provide a TB test for R8 and indicated R8 had only been at the facility for two weeks. Severity: 2 Scope: 1	0936	1. R8 step1 TB test was done on10/03/18 and step2 TB test was completed on 10/9/18. TB Screening was Re-done on 6/28/19 and Step2 is scheduled on 7/8/19. 2. The facility will ensure complete requirements of the resident's records before admitting a resident to the facility. 3. The admitting staff of the facility will coordinate with the family and discharge coordinator from the discharging facility to provide complete paperworks before sending the resident to our facility. 4. The facility owner is responsible to ensure that the facility is compliant with the regulations by checking the resident's file by the use of the Resident File Checklist. 5/3/19	06/23/2019

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0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an evaluation of a resident's activity of daily living (ADL) was completed upon admission for 1 of 7 residents (Resident #8). Findings include: Resident #8 (R8) R8 was admitted approximately on 04/17/19, with diagnoses unknown. R8's file lacked documented evidence of an admission date and a diagnosis. On 05/02/19, at 11:00 AM, R8's file lacked documented evidence R8's ADL's were evaluated upon admission. The Caregiver was unable to provide an evaluations of R8's ADL's and indicated R8 had only been at the facility for two weeks. Severity: 2 Scope: 1	0938	1. R8 Admission and needs assessment had been completed on 4/17/19 2. The facility in charge of admitting a new patient at the facility has to complete the admission assessment of a resident immediately after admission. 3. The facility owner will double check the complete requirements of a resident by the use of employee file checklist. 4. The facility owner is responsible to ensure facility is compliant with the regulations by supervising staffs with the admission procedure and double check the completeness of the resident's file. 5/3/19	06/23/2019
0966 SS= F	Alzheimer’s Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general	0966	1. Employee#4 had been terminated employment. 2. The facility administration always required the staffs not to leave the facility	06/04/2019

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	requirements. (NRS 449.0302) 5. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on observation and interview, the facility failed to ensure the staffing ratio for seven residents was maintained. Findings include: On 05/02/19 at 10:45 AM, upon arrival Caregiver #4 answered the door and Caregiver #3 was walking in the side door with a bag of groceries. Caregiver #4 indicated Caregiver #3 had gone across the street to the owner's other home to get food. The Caregiver was unaware of the Caregiver to resident ratio. Another person was sitting at the kitchen table and informed the surveyor she was not a Caregiver but Caregiver #3's spouse. Caregiver #4 acknowledged he was the only Caregiver at the facility while Caregiver #3 went across the street. At 11:00 AM, Caregiver #4 was unable to provide Resident #8's file and left the facility to get the file from across the street at the other home. During this time, there was only one Caregiver at the facility to seven residents. At 11:30 AM, Caregiver #4 was unable to provide the staff files and left the facility to get the files from across the street at the other home. During this time, there was only one Caregiver at the facility to seven residents. At 12:15 PM, Caregiver #4 was unable to provide the Medication Administration Record and left the facility to get the record from across the street at the other home. During this time, there was only one Caregiver at the facility to seven residents. At 1:00 PM, Caregiver #4 was not present and Caregiver #3 did not know where the Caregiver went. At 2:00 PM, after an hour, Caregiver #4 still had not returned. The surveyor went across the street and the		premises at all times. 3. The facility owner will supervise the daily operation and staffing of the facility and always instructed the staffs not to leave the premises of the facility at all times per staffing required. 4. The facility owner is responsible to ensure facility staffing compliance by scheduling staffs required 5. 5/3/19	

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	Caregiver at the owner's other home indicated Caregiver #4 had just left out the back door. Upon return to the facility, Caregiver #4 indicated he was across the street fixing a leak and acknowledged he had left and was not supposed to. Severity: 2 Scope: 3			
0992 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. (d) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes the training and continuing education required pursuant to NAC 449.2768. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure a staff member was awake at night while residents slept. Findings include: On 04/30/19 in the morning during a tour of the facility, a Caregiver bedroom was observed onsite. On 04/30/19 in the morning, a Caregiver indicated the Caregiver bedroom was where the Caregiver slept at night. The Caregiver indicated residents were checked at 9:00 PM, 11:00 PM, between 1:00 AM and 2:00 AM and between 5:00 AM and 6:00 AM. The Caregiver indicated the Caregiver slept at 10:00 PM, 12:00 AM and between 3:00 AM and 4:00 AM. Review of the staffing schedule for April 2019, documented one staff member was available on the night shift. On 04/30/19 in the morning, R4 indicated R4 had observed the Caregivers asleep on the couch at night. R4 was unaware whether the	0992	1. Employee#3 is terminated. New night person is hired. 2. The facility has a designated night person who is awake at night to tend to resident when needed. 3. The facility owner will constantly interview residents for night staff service at night. 4. The facility owner will ensure facility compliance with the regulations on staffing at night by constant interview with the residents about their concerns including services and staffs performances. The Administrator will continue to conduct staff training on the regulations regarding job descriptions of the caregivers. The facility will keep records of the training subject that was conducted with the signature of the staffs attended. 5. 5/3/19	06/23/2019

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	Caregivers checked on the residents because they were sleeping, along with the residents. R4 indicated if R4 needed help, R4 would have yelled for staff to wake up. On 04/30/19 in the morning, R6 indicated the Caregivers slept in the bedroom at night. R6 indicated if R6 needed help, R6 would knock on the Caregiver's bedroom door. On 04/30/19 in the morning, R7 indicated R7 had a broken leg and had gone to rehabilitation and was doing better. R7 indicated the Caregivers slept at night, but were always available to help residents. R7 indicated if R7 needed a Caregiver in the middle of the night, R7 would knock on the Caregiver's bedroom door. Severity: 2 Scope: 3 Complaint #NV00056887 On 05/02/19 at 11:00 AM, Caregiver #4 reported he worked during the day and Caregiver #3 worked at night. Caregiver #3 was awake and scheduled to work during the day and night. Caregiver #3 indicated he slept on the couch at night and did not stay up all night. Severity: 2 Scope: 3			